	28-'10 16:49 FRC			) 1	T-6	90 P0002/000! FURW	5 F-820 APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  Bureau of Health Care Quality and Compliance Cupter  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					Mynay PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		NVN3784ADA		A. BUILDIN B. WING		10/0	5/2010	
NAME OF F	ROVIDER OR SUPPLIER	INTOTALA	STREET ADI	DRESS, CITY, :	STATE, ZIP CODE	10/0	<u></u>	
RIDGE H	IOUSE III		990 CAME RENO, NV					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 000	Initial Comment			D 000				
	by the Health Divisi- prohibiting any crim actions or other clai	onclusions of any invo on shali not be consi inal or civil investiga ims for relief that ma ty under applicable f	rued as tions, v be					
	a result of the State at your facility on 10 survey was conduct	Deficiencies was gent Licensure survey co 0/5/10. This State Lic ted by the authority of the Health Division.	onducted censure		·			
	beds for the treatmedrugs. The census six. Six resident file	ed for six residential ent of abuse of alcoh at the time of the su es and four employed e discharged resider	ol and rvey was e files					
D 108 SS=F	NAC 449.123(4)(a)	Sanitary Requireme	nts	D 108				
	in a sanitary condition (a) The facility mus	t have the necessar quipment with suffici appropriate procedur	y cleaning ent es to	·				
	This Regulation is r Based on observation the facility failed to r equipment in a sanit stove had a broken potential burn hazar preparing meals. Severity: 1 Scope:	on and interview on maintain the facility's tary condition. The f inner window posing d for residents wher	10/5/10 facility		A new stove was purch installed.  Monthly house check checking all appliance operation.	s now include	10/19/2010   &K   M	
1			returned with	in 10 days aft	l ter receipt of this statement of de	ficiencies.	000 5 2 7 7	
PARATANY	DIFFERTORIE OD DESE ***	#BIOLIDOLINO 0#====			TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM

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T-690 P0003/0005 F-820 FURM APPROVED

Bureau	of Health Care Quali	ty and Compliance				FURIVI :	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF	PROVIDER OR SUPPLIED	NVN3784ADA	STREET AD	DDEOG AITY	DTATE 7/0 0005	10/0	05/2010	
NAME OF PROVIDER OR SUPPLIER STREET AD  RIDGE HOUSE III 990 CAMI RENO, NA								
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCY)	TION SHOULD BE THE APPROPRIATE		
D 122 SS=F	2. The laundry must is separate from an prepared or served. well-lighted, ventilate the equipment and manner. The equipment and manner. The equipment and manner. The equipment is repair.  This Regulation is repaired to passed on observation the facility failed to plarge amount of lint.	st be situated in an arc y area where food is so The laundry must be ed, adequate in size to maintained in a sanita ment must be kept in a not met as evidenced on and interview on 10 prevent the accumulati behind the dryer in the	stored, to house ary good by: 0/5/10, tion of a	D 122	The dryer vent has been reconnected and all lint vacuumed and removed.		10/06/2010	
D 217 SS=F	garage creating a fire hazard.  Severity: 2 Scope: 3  NAC 449.141(9) Health Services  9. Each facility shall maintain and have readily available first-aid supplies. Staff members shall have evidence that they have received training on the use of first-aid supplies.			D 217	Monthly house checks now incohecking the dryer for cleanlin and lint removal.		SK M	
	Based on observation the facility failed to he cardiopulmonary res	uscitation available a on hand to respond t	10/5/10, s part of	D A89	A cardiopulmonary resuscitation mask has been purchased and placed with the 1 <sup>st</sup> aid supplies.  The House Manager is responsion ensuring that 1 <sup>st</sup> aid supplies av including a CPR mask.	ible for	10/18/2010 OK, MH	

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NAME OF PROVIDER OR SUPPLIER  RIDGE HOUSE III  SUMMARY STATEMENT OF DEFICIENCES BY FULL TAG  CABULATORY OR LSC IDENTIFYING INFORMATION)  D A89  Continued From page 2  11. A personnel record must be maintained for each employee. The record must contain: (a) The employment application; (b) Letters of recommendation; (c) Reference investigation records; (d) Verification of training, experience and certification; (e) Job performance evaluations; (f) Incident reports; and (g) Disciplinary actions taken.  12. Personnel records must be maintained in a secure manner and must be available only to those persons authorized in written policies and procedures. An employee must have access to his own file upon request.  This Beautetian is not matched and procedures. A subject to the procedure of the procedure of the procedure of the policies and procedures. An employee must have access to his own file upon request.	Bureau	of Health Care Quali	ity and Compliance				FORM	APPROVED	
RIDGE HOUSE III  STREET ADDRESS, CITY, STATE, ZIP CODE 990 CAMBRIDGE RENO, NV 89502  CA4) ID PREVIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D A89  Continued From page 2  11. A personnel record must be maintained for each employee. The record must contain: (a) The employment application; (b) Letters of recommendation; (c) Reference investigation records; (d) Verification of training, experience and certification; (e) Job performance evaluations; (f) Incident reports; and (g) Disciplinary actions taken.  12. Personnel record must be maintained in a secure manner and must be available only to those persons authorized in written policies and procedures. An employee must have access to his own file upon request.  This Regulation is not met as evidenced by: Based on record review and interview on 10/5/10, the facility failed to conduct an annual evaluation of the performance of 1 of 4 employees (Employee #3).  Severity: 1 Scope: 1  Severity: 1 Scope: 1	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ER/CLIA MBER;	A. BUILDING					
RIDGE HOUSE III    SUMMARY STATEMENT OF DEPICIENCES   RENO, NV 89502	NAME OF F	ROVIDER OR SUPPLIER	MANALOTANA	STREET AD	IDBESS CITY	STATE 7IP CODE	10/0	J5/2010	
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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM